RACs Launch New Semi-Automated Reviews That Require Hospital Documentation

Recovery audit contractors (RACs) have debuted a new type of overpayment identification — “semi-automated reviews” — that require hospitals to submit documentation if they want to rebut a presumption that their claims are invalid.

Semi-automated reviews sound like automated reviews because they are based on CMS claims analysis and appear to steer clear of MS-DRG coding validation and medical necessity. But semi-automated reviews may have more in common with complex reviews because hospitals must submit medical records unless they’re willing to sacrifice their reimbursement without a fight.

The great unknown is whether there’s a cap on the number of semi-automated reviews that RACs can perform at each hospital, says Heidi Shirk, RAC program coordinator for Penn State Milton Hershey Medical Center in Hershey, Pa.

RACs can do unlimited automated reviews because hospitals aren’t required to submit medical records as a part of the process, unless they appeal. However, CMS caps the number of complex reviews RACs may conduct every 45 days, because providers would otherwise be crushed by the demands of medical-record production inherent in this type of audit. The cap varies by provider type, although recently CMS upped the limit to 500 per hospital every 45 days. CMS has not indicated whether there’s a ceiling for semi-automated reviews, and CMS officials in charge of the RAC program did not respond to requests for an interview.

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Kyphoplasty Case Is Full of Surprises as Another Hospital Settles, Others Self-Audit

The national false-claims investigation of inpatient kyphoplasty is taking some unusual twists and turns. The latest settlement — with Rex Healthcare in Raleigh, N.C. — may open a new chapter in the Department of Justice’s medical-necessity enforcement initiative because it involved other inpatient surgeries that allegedly should have been performed in an outpatient setting.

Meanwhile, some hospitals are hoping to nip false-claims lawsuits in the bud by returning kyphoplasty reimbursement to their Medicare administrative contractors (MACs).

The investigation of kyphoplasty — a procedure to treat spinal fractures — is controversial because, according to lawyers and compliance officers, there is support for the medical necessity of inpatient kyphoplasty, based on information from InterQual, CMS and Coding Clinic, for example.

But DOJ is not challenging all inpatient kyphoplasties — only the practice of categorically performing them on inpatients, without physicians deciding the appropriate site of service based on the patients’ medical circumstances, according to Robert Trusiak, chief
of the affirmative civil enforcement unit at the U.S. Attorney’s Office for the Western District of New York. Trusiak, who runs the multi-jurisdictional investigation of inpatient claims for kyphoplasty, focuses on admission decisions that are allegedly driven by the profit motive rather than individualized patient assessment (RMC 6/29/09, p. 1).

The medical necessity of the kyphoplasty procedure itself is not under attack. Rather, the feds are challenging whether hospitals are performing them on an inpatient basis to leverage more Medicare reimbursement when an outpatient setting would be sufficient.

Hospitals are paid $12,000 to $15,000 for an inpatient kyphoplasty compared with $2,500 to $4,500 under the outpatient prospective payment system. It’s one thing to admit an inpatient because of comorbid conditions; it’s another thing if there are standing orders and hospitals encourage physicians to do all of the procedures in-house, Trusiak says.

The national investigation kicked off in 2005 with a false claims lawsuit filed by two whistleblowers against Kyphon, Inc., the company that developed kyphoplasty and marketed a kit used in the procedure. The whistleblowers alleged that Kyphon embarked on a seven-year marketing campaign to persuade hospitals to perform kyphoplasty as an inpatient procedure when it should have been done on an outpatient basis. Kyphon’s corporate successor, Medtronic Spine LLC, paid $75 million in May 2008 to settle the case with DOJ.

Hospital Repays Medicare as a Deterrent

The whistleblowers then lodged the same false-claims allegations against hospitals in a separate filing, and the dominos began to fall in 2009 (RMC 5/25/09, p. 5). The latest is 655-bed Rex Healthcare, which agreed to pay $1.9 million to settle the kyphoplasty case but denies the allegations, according to the settlement, DOJ said April 4. Although Rex is the 26th hospital to resolve allegations stemming from the kyphoplasty investigation, it’s unique because “kyphoplasty matters were not the majority” of procedures at issue in the settlement, Trusiak tells RMC. Instead, other similar short-day admissions drove up the settlement amount.

Trusiak explains that 93% of Rex Healthcare’s kyphoplasty admissions were zero- to one-day stays — making it the third-highest in the nation — so he worked with the U.S. attorney’s office for the Eastern District of North Carolina to develop the case, which was based on a billing analysis, witness interviews and other documentary evidence. During the investigation, the government became aware of other types of one-day inpatient stays of questionable medical necessity. Trusiak declined to specify which procedures besides kyphoplasty were part of the settlement.

“Given what I understand about the practices of some hospitals, this issue of inpatient or outpatient is not restricted to kyphoplasty,” says Tim McCormack, the whistleblowers’ attorney, who is with Phillips & Cohen in Washington, D.C. “I wouldn’t be surprised to see investigations proceed similarly with other hospitals,” with prosecutors from different jurisdictions collaborating, McCormack says.

Meanwhile, hospitals that have not been approached by Trusiak may take matters into their own hands. About a month ago, one hospital returned $1 million in Medicare reimbursements for inpatient kyphoplasty to its Medicare administrative contractor (MAC), says the compliance officer, who preferred not to be identified.

The compliance officer reviewed the hospital’s 2002 to 2008 kyphoplasty cases and disallowed them unless patients had comorbid conditions requiring their admission.

These enforcement initiatives are not one of the government’s finer moments, the compliance officer says. It had been de rigeur for years to perform the procedure on an inpatient basis. InterQual, the admission screening tool, recommended inpatient admission for kyphoplasty between 2003 and May 2008.
“If patients meet InterQual criteria for kyphoplasty, how could they not be inpatients? Shouldn’t we have a minimum threshold, where no one comes back on you and says, ‘I don’t care if you meet InterQual or not?’” the compliance officer asks. “I understand when you can’t fit patients in little InterQual boxes” and therefore admission necessity is in doubt and physicians and hospital case managers sort things out. But this is the reverse situation, the compliance officer notes. “If InterQual is not a guide and a tool that puts us in a safe place, what good is it?”

If the MAC accepts the hospital’s repayment, it will be the closest it may come to a happy medium — no fines or penalties, although repayment on claims despite the fact “we thought we were doing inpatient kyphoplasties in good faith.” There’s been no word from the MAC, although only a month has gone by. The MAC could still refer the hospital to the Department of Justice.

**Wait-and-See Approach Could Be Costly**

Other hospitals are considering similar pre-emptive actions. One lawyer who represents hospitals under investigation for kyphoplasty says he also has hospital clients that are self-auditing kyphoplasty reviews (under attorney-client privilege) even though they have not been contacted by Trusiak. “The hospitals are reviewing what their potential liability might be,” says the attorney, who did not want to be identified to protect clients potentially embroiled in an ongoing investigation. If they find what the government would consider errors, the attorney “would feel comfortable advising them” to treat it as a Medicare repayment, sending a check to the MAC, “and letting the chips fall where they may.”

In the eyes of the hospital-clients, kyphoplasty is not false-claims fodder, the attorney says. To rise to the level of a False Claims Act violation, he says, hospitals had to act with reckless disregard or deliberate ignorance. “The legacy of this procedure lends itself to the argument that the guidance provided by the government and other sources created significant ambiguity about the appropriate site of service for this procedure,” he says.

In addition to the InterQual criteria, on July 30, 2008, CMS posted a list of topics it was considering for national coverage decision (NCD) development, including kyphoplasty and a related procedure, vertebroplasty. CMS stated that “typically, vertebroplasies are performed in an outpatient setting, while kyphoplasty typically requires hospital admission.” (No NCD was ever published on kyphoplasty.) Also, Coding Clinic, the newsletter published by the American Hospital Assn., said in its fourth-quarter 2004 edition that “kyphoplasty is typically performed in an inpatient setting.”

There is a downside to pre-emptive MAC repayments for inpatient kyphoplasties, especially when hospitals aren’t convinced of their liability, says another attorney, who also declines to be identified because of the ongoing investigation. The feds can still come after a hospital that repaid alleged kyphoplasty overpayments, and the act of refunding them sacrifices the hospital’s defense in a false claims case, he says. “How do you defend [yourself] if you cut a check to the government?”

But self-disclosure also has its advantages, as Trusiak notes that the False Claims Act caps damages at double when parties self-disclose.

To ensure kyphoplasty site-of-service compliance moving forward, the hospital’s providers and case management staff have been educated and “patients will only be inpatients if there are other co-morbid conditions that warrant the admission,” the compliance officer says. It’s a good idea, he adds, to monitor the volume of inpatients admitted for the spine procedure. “Ours dropped dramatically in 2008 when it became known that kyphoplasty cases could be safely treated as outpatients,” the compli-

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- **A Guide to Complying With Stark Physician Self-Referral Rules**, a comprehensive looseleaf (plus quarterly updates) with practical summaries of the federal rules and separate analyses for hospitals, physician groups and other stakeholders.

- **Conducting Internal Investigations in Health Care Organizations**, guidance on conducting an internal investigation from start to finish. Written by former HHS IG Richard Kusserow, the book also contains more than 30 adaptable policy and form templates (in print and on an accompanying CD).

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ance officer says. A recent review at the hospital found no questionable claims in this area.

An attorney representing Rex Healthcare did not respond to RMC’s requests for comment and the vice president of medical affairs did not return a phone call. Trusiak praised Rex for its cooperation. The Rex settlement comes barely three months after hospitals in Alabama, Florida, Mississippi, North Carolina, South Carolina and Texas paid a total of $6.3 million to settle allegations in the national kyphoplasty enforcement initiative (RMC 1/17/11, p. 3).

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One Error, 192 Fines: Deconstructing The Mass General HIPAA Case

The way that two recent privacy violations were resolved by the HHS Office for Civil Rights is a sign that the HIPAA enforcement tide has turned. With OCR’s increased funding and the authority to levy stiffer penalties, OCR has the wherewithal to put its money where its mouth is.

In addition to being a loud wake-up call, the new investigations and greater enforcement provide covered entities with more insight they can use to reassess their HIPAA compliance programs, experts say.

“The enforcement landscape has changed,” Minneapolis attorney Steve Lokensgard said March 30 at a Health Care Compliance Assn. (HCCA) webinar.

Massachusetts General Hospital agreed to pay $1 million to settle potential HIPAA privacy violations over confidential paperwork that an employee accidentally left on the Boston subway in March 2009 (RMC 3/14/11, p. 1). Cignet Health Center, a Temple Hills, Md., medical group, paid OCR $4.3 million to settle allegations it refused to give some patients copies of their medical records and then dug in its heels when OCR investigated.

In the Mass General case, the employee left with daily office schedules so she could work at home. They contained names and medical records for 192 patients, but 66 were also billing encounter forms with names, dates of birth, medical record numbers, health insurer and policy numbers, diagnoses and provider names. Some of the patients had an HIV/AIDS diagnoses. On her way to work the next morning, the Mass General employee — a low-level billing administrator — left the paperwork on the subway seat, and two years later it has yet to materialize.

“Cignet got a higher fine, but Mass General caught everyone’s attention because everyone takes work home,” Lokensgard said.

What’s ominous about the $1 million fine is that it means OCR did not hit Mass General for one failure (i.e., the employee’s loss of the medical records), said Lokensgard, who is with Faegre & Benson. Instead, OCR charged the hospital a fine for each of the 192 records lost, he says. Here’s the math: $1 million divided by 192 records equals $5,200 per record, which lines up with the enhanced penalties under the HITECH Act.

Lokensgard said it appears that OCR penalized Mass General’s alleged violation according to the second of the four tiers in the HITECH violation hierarchy. That amounts to a $50,000 civil monetary penalty per violation. The lowest fine in the four tiers — for innocent mistakes (“did not know”) — is $100 to $50,000 per violation. The third is willful neglect, corrected, with a per-violation CMP of $10,000 to $50,000. And the fourth and highest is willful neglect, not corrected, with a per-violation CMP of $50,000. All tiers carry a $1.5 million maximum penalty.

In other words, OCR saw more than a careless mistake, and in fact, extracted a settlement close to the maximum, Lokensgard said. There are important messages here, he said. “It’s important to remind people that even if it was a mistake, if there’s an intervening event, such as the theft of a laptop, there’s no excuse” — and OCR will not suffer these breaches gladly. “Information should be protected.”

OCR Is Developing Common Format for CAPs

As part of the resolution of its case with OCR, Mass General was required to implement a corrective action plan (CAP). “OCR is developing a common format” for corrective action plans after doing them for about three years, he says, analogous to the HHS Office of Inspector General’s corporate integrity agreements, which are compliance programs mandated in fraud settlements. The OCR template means “there may be relatively few things to negotiate when entering into corrective action plans,” Lokensgard said.

CAPs typically last three years. They require policies and procedures designed to prevent and detect “the bad behavior that got them in trouble,” he said. Under Mass General’s corrective action plan, the hospital is required to get OCR’s approval for its new-and-improved policies and procedures and disseminate them within 30 days. Mass General also has 90 days to train employees on the policies and procedures. “You have to give OCR a copy of the training so presumably if it’s too short or not thorough enough, OCR would talk to you about it,” Lokensgard said.

OCR also requires covered entities to appoint monitors to oversee compliance with corrective action plans and submit monitoring plans to OCR. In Mass General’s case, it was agreed that its director of internal auditing...
would serve as the monitor, which is unusual. In the OCR's settlements with CVS and Rite Aid, for example, external auditors were required. To check on HIPAA compliance, the monitor must make unannounced site inspections, and sample flash drives and laptops to make sure they are encrypted, Lokensgard says. Monitors are required to do random employee interviews to make sure education is sinking in, he said.

In the Cignet case, OCR alleged there were 41 violations from November 2008 to April 2010. The fine was based on $100 per day, per patient, for alleged failure to give patients copies of their medical records and $50,000 per day, per patient for failure to cooperate with OCR's investigation even in the face of a subpoena, Lokensgard said. Because Cignet didn't give patients their medical records before HITECH took effect, it was fined at HIPAA's lower rates, but the “failure to cooperate with OCR was charged with HITECH fines,” Lokensgard noted.

OCR Is Flexing New Muscles

Both cases reflect OCR's new muscle-flexing. There has been a 25% increase in full-time employees and the fiscal year 2011 budget calls for 10 new privacy advisers. In the past, OCR had a backlog of complaints, and often a year elapsed before OCR questioned a health system. But OCR moves faster now, and questions health systems in much greater detail when complaints are lodged. If OCR doesn’t like what it hears, it has the HITECH-granted power to impose significantly higher fines than under HIPAA.

Covered entities should respond in kind, reassessing and strengthening their HIPAA compliance programs. It’s a good time because OCR audits of privacy and security compliance are on the way. The HITECH Act requires OCR to develop a HIPAA audit program to scrutinize covered entities and business associates, as well as to fund a study to find the best means of performing the audits and to set audit protocols. The completed study by Booz Allen Hamilton is not publicly available. There is no word yet on when audits will begin, but OCR's 2011 budget will release additional funding for audits this year.

At the HCCA webinar, Jenny Bernhard, privacy officer for Regional Health in Rapid City, S.D., gave tips for re-evaluating your HIPAA compliance and identifying where it may be necessary, for example, to improve policies and procedures and target auditing and monitoring:

1. **Review breaches described on OCR’s “wall of shame”** because they flag areas that may need more/better oversight, training and policies and procedures (see www.hhs.gov/privacy/hipaa/administrative/breach-notificationrule/breachtool.html). For example, given Mass General’s snafu, think about employees’ removal of records from the workplace. “If they had placed medical records in [a bag] that was zippered and marked confidential, would it have mitigated the penalty?” she said. Under new HITECH breach reporting rules, breaches posted on the OCR website affect more than 500 people. According to the log, 78% of people affected by breaches stem from 10 incidents, and half of them are theft of storage media, Bernhard said.

2. **Study OCR’s enforcement activity,** also in detail on the HHS website (www.hhs.gov/ocr/privacy/index.html). Consider your own policies and procedures in the context of the top complaints filed with OCR. The no. 1 and 2 patient complaints under investigation by OCR are, respectively, impermissible uses and disclosures and lack of safeguards. They go hand in hand, Bernhard said. “If you don’t have the appropriate safeguards to protect PHI, you will typically have impermissible disclosures,” Bernhard notes. “Take notice that OCR is really paying attention to these top two issues.” The third most frequent complaint being investigated by OCR is lack of patient access to their PHI; fourth is covered entities using and disclosing more PHI than the minimum necessary; and fifth is complaints to the covered entity.

3. **Consider “near misses and potential violations,”** Bernhard says. Perhaps you are hearing a lot about hospital/patient gossip on social media sites. Maybe it won’t amount to anything, but all that chatter is a red flag.

4. **Assess risks.** EMRs are great tools for efficiency and quality-of-care improvement, but they have made access audits more important, Bernhard notes. For example, run reports on areas of concern. Did a nurse working at one location access the records of a patient from another? If so, why? Also, she says, “who accessed VIPs from the news last night?” Portable devices, such as flash drives, are another high-risk area because they can hold a lot of data.

5. **Prioritize risks and create or refine policies and procedures based on risk-assessment results.** For example, “given the breach log and guidance from OCR, has our organization addressed the use of portable encryption? What about theft? Are there policies and procedures to address these high-risk areas?” Perhaps there is a compliance gap with telephone-message verification. When other providers call for PHI, how do hospital staff verify their identity?

6. **Train the workforce** — employees, volunteers, trainees, students — in a way that hits home. “Without education, policies are just words on a page,” Bernhard notes. Keep privacy and security in their face (e.g., through e-mails and newsletters). “Tell employees it is a compliance gap with telephone-message verification. When other providers call for PHI, how do hospital staff verify their identity?”

Contact Bernhard at jbernhard@regionalhealth.com and Lokensgard at slokensgard@faegre.com.

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CMS to Release Billing-Compliance Data for CAHs and Podiatrists

CMS said April 5 it is unveiling two more tools that providers can use in their compliance auditing: PEPPER data for critical access hospitals (CAHs), and another round of comparative billing reports (CBRs), this time for podiatrists.

Starting April 25, CMS for the first time will begin to distribute PEPPERS — the Program for Evaluating Payment Patterns Electronic Reports — for the country’s 1,300 CAHs. Hospitals will receive them through QualityNet, CMS’s secure website for communications between QIOs and providers.

PEPPERS are free electronic reports showing hospital billing outliers in certain coding and admission necessity risk areas, which had been produced only for short-term acute-care hospitals and long-term-care hospitals until the PEPPER contractor revealed in February that they would be available to CAHs as well (RMC 2/7/11, p. 4).

CAHs are small, rural facilities for which admission necessity is a greater concern because they are not paid based on MS-DRGs. CAHs are also becoming an audit target.

According to CMS, PEPPER will be the only free report available to CAHs to compare their Medicare billing practices with other CAHs by state, Medicare administrative contractor or fiscal intermediary jurisdiction, and nationally.

CMS also announced it would release its fifth CBR in April on selected services billed by podiatrists, which will go to about 5,000 practices nationwide. “The data in this report illustrates peer comparisons of debridement codes billed, evaluation and management high level code use, and the number of patients billed per day in both the office and skilled nursing facility settings,” CMS says in an April 4 listserv e-mail.

PEPPERs Reveal Utilization Patterns

Like PEPPERS, CBRs allow providers to compare data to that of their peers by giving “utilization patterns for services, beneficiaries, and diagnoses billed,” CMS says. The agency hopes the information will prevent improper payments by showing providers where they are at risk for overpayments and underpayments.

Most provider types are eligible to receive CBRs, including hospital outpatient providers, hospices, labs, ambulances, skilled nursing facilities, home health agencies and chiropractors (RMC 8/23/10, p. 1). Physicians and inpatient hospital providers are not eligible. CBRs, produced by SafeGuard Services, have already been released for physical therapists, chiropractors, emergency transports and certain non-emergency transports.

These reports are “a way to draw [providers’] attention when their billing patterns are unusually high or unusually low…and it may help them identify some areas of improper payments,” says Kim Hrehor, project director for TMF Health Quality Institute, the Texas-based Medicare quality improvement organization that generates PEPPERs for CMS. But the reports do not identify the presence of improper payments, she points out. Errors “can only be seen in a review of medical documentation. These are just an indicator, and then it is up to the provider to do their due diligence,” she tells RMC.

A new PEPPER product for inpatient psychiatric facilities will come out in June, and one for inpatient rehabilitation facilities will be ready in September, Hrehor adds.

TMF will conduct a web-based training session for CAHs on April 28 to provide information on how to use PEPPER, CMS adds in an April 4 listserv e-mail. Visit https://tmfevents.webex.com. The training will also be posted later at www.pepperresources.org.


RACs Launch New Type of Review

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According to the CMS website, there are two parts to semi-automated reviews:

1. The RAC’s automated review process identifies a billing aberration with a “high index of suspicion to be an improper payment.”

2. The provider gets a “notification letter” from the RAC, which explains the existence of the potential billing error. The RAC gives the provider 45 days to produce documentation to support the claim. If the RAC agrees with the provider, all is good. However, CMS says, “if the provider decides not to submit documentation, or if the documentation provided does not support the way the claim was billed, the claim will be sent to the Medicare claims processing contractor for adjustment and a demand letter will be issued.” In other words, the claim will be denied.

“My concern is volume and my fear is they won’t have a cap,” Shirk says. “I hope CMS keeps in mind that there is no cap on automated reviews. They should take into consideration how many medical records they are asking for so they don’t put a huge burden on facilities.”

Certain types of claims seem ripe for semi-automated reviews because they fall through the cracks of automated reviews (which don’t use medical records) but are not complex review material (because they are not MS-DRG
or medical necessity-related), Shirk says. A big one is modifier 59, which physicians and hospitals use to override Correct Coding Initiative (CCI) edits. CCI edits are designed to prevent inappropriate coding that causes Medicare overpayments. Medicare won’t pay separately for certain services when they are performed on the same patient at the same time. But providers can override edits with modifier 59. Suppose the physician performs a (1) adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 square cm or less (CPT 14040) and (2) repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm (CPT 13131).

“If these codes are billed together on the same claim — same date of service — you will receive an unbundling edit,” Shirk says. But providers are allowed to override the edit with modifier 59 if documentation supports the fact that separate services took place, she says. For example, modifier 59 is justified when a physician performs both procedures on the patient’s forehead and chin at the same time. “What the RACs would be looking for is the separateness to warrant being paid for both,” she notes.

Semi-automated reviews are also tailor-made for medically unlikely edits (MUEs). CMS uses MUEs to block payment for services that, on their face, don’t make sense, and has assigned a maximum allowable number of times providers can bill for certain CPT codes. “They’re just arbitrary numbers, but it’s un

providers can’t bill more than three of these procedures on each patient per date of service. It’s conceivable it would be justified, however, so Shirk says that hospitals may want to fight back if RACs hit MUEs during semi-automated reviews.

Shirk emphasizes she is speculating that modifier 59 and MUEs could be targets for semi-automated reviews. Until they occur, or CMS or the RACs provide more information, there’s no way to know.

Wendy Trout, director of corporate compliance and revenue management at WellSpan, thinks semi-automated reviews sound promising. She thinks there will be more clarity than hospitals have experienced so far with automated reviews, in which the RAC sends vague demand letters stating an overpayment amount and a general reason (e.g., denied due to CCI edits) without specifying which line items were implicated. That forces hospitals to decipher which line items were denied and, if indicated, to set the RAC straight during the discussion period — and to do all that within 45 days. Automated reviews were supposed to be black and white — simple errors, such as billing for three cataract surgeries — but it hasn’t turned out that way, Trout says. Hospitals wind up chasing down money that Medicare recouped inappropriately from RAC automated reviews, which is “an administrative nightmare.”

Read about semi-automated reviews on the CMS website at http://questions.cms.hhs.gov/app/answers/detail/a_id/10430/p/8%2C7%2C496%2C497/session/L3NpZC90bjJwOGtxaw%3D%3D. Contact Shirk at hshirk@hmc.psu.edu and Trout at wtrout@wellspan.org.

**NEWS BRIEFS**

◆ CMS issued guidance March 25 that clarifies the health reform law’s provisions on Medicaid payment suspensions. Under the health reform law, states will not receive the federal portion of Medicaid payments for services by providers who are under investigation for a “credible allegation of fraud.” CMS explains in a new bulletin and frequently asked questions that states should verify whether the fraud allegations are credible before suspending payments. States also can forgo the payment suspension for good cause. One example of good cause is providers proving “that a payment suspension should be terminated or imposed only in part.” To read the bulletin, visit RMC’s April 8 From the Editor entry at http://aishealth.com/newsletters/reportonmedicarecompliance.

◆ A bill introduced recently by Sen. Chuck Grassley (R-Iowa) would lengthen the amount of time CMS has to pay claims to providers suspected of defrauding Medicare. Under the “Strengthening Program Integrity and Accountability in Health Care Act of 2011” (S. 454), HHS would be able to delay payment of claims to providers in certain categories or geographic areas for 365 calendar days. For individual providers, HHS can extend the payment deadline until “such time as the secretary determines is necessary to ensure that the claims…are clean claims.” During the extensions, HHS will conduct prepayment reviews and other scrutiny, according to the bill. While the health reform law gave HHS the authority to suspend payments to suspect providers, this bill says HHS must extend the payment time and
NEWS BRIEFS

review the claims. Other provisions in the bill would work to prevent medical identity theft and expand permissive exclusion to individuals affiliated with sanctioned entities, among other things. Read the bill at http://thomas.loc.gov.

◆ A Connecticut physician has agreed to pay the federal government almost $380,000 to settle allegations that he improperly billed Medicare for some evaluation and management (E/M) services, the U.S. Attorney’s Office for the District of Connecticut said March 31. William Garrity, D.O., who has a practice in Suffield, Conn., treats patients using osteopathic manipulative treatment (OMT). “Data analysis of Garrity’s practice indicated that approximately 95 percent of the time that he billed Medicare for OMT, he also billed Medicare for an evaluation and management service, using a special billing modifier (modifier 25), which allowed payment for both the OMT procedure and the evaluation and management service on the same day,” the feds say in a press release. Medicare normally will not pay for an E/M service performed on the same day as a procedure unless the E/M service is significant and separately identifiable. In that case, modifier 25 can be used for additional payment for the separate E/M service, the feds explain. A “review of Garrity’s medical records has revealed that there often was no documentation of a significant, separately identifiable reason for the patient’s visit (i.e., the patient was there only for regularly scheduled OMT services), there was often no documentation of the medical necessity for the evaluation and management services, and there was often no documentation that evaluation and management services had been performed at all,” the feds say. Garrity does not admit liability, according to the agreement, but settled to avoid the delay, uncertainty, inconvenience and expense of litigation. Visit www.justice.gov/usao/ct.

◆ The Department of Justice has filed a False Claims Act lawsuit against the biopharmaceutical company Healthpoint Ltd., alleging that it caused submission of false or fraudulent claims for an unapproved drug. The drug, Xenaderm, was launched in 2002 without FDA approval to treat decubitus ulcers. The active ingredient in the drug is trypsin, which is supposed to remove dead tissue, but the FDA found in the 1970s that it is ineffective, and has not approved any drug containing it since then. That makes Xenaderm ineligible for Medicare and Medicaid reimbursement, the feds point out. Drug makers submit to CMS in quarterly reports the Drug Efficacy Study Implementation (DESI) code of each of their products. According to DOJ’s complaint, Healthpoint allegedly “gamed the system” by hiding the drug’s actual DESI code from providers and federal health care programs, and by submitting false quarterly statements to CMS on Xenaderm’s eligibility. As a result, the company caused false claims to be submitted, and the federal government paid almost $90 million for an ineligible drug between 2002 and 2006. A spokesperson for the company did not respond to a request for comment. To read more, visit www.justice.gov and click on “Briefing Room.”

◆ One of the cardiologists implicated in a scheme in which the University of Medicine and Dentistry of New Jersey (UMDNJ) allegedly paid kickbacks for patient referrals has been cleared by a federal jury, the attorney representing him tells RMC. The feds alleged that, beginning in 1995, UMDNJ was in need of performance data on cardiology procedures to maintain state and federal funding, so it entered into part-time employment contracts with nine cardiologists. But instead of performing services for the hospital, the physicians allegedly were paid salaries solely as kickbacks for their patient referrals, the feds contended. UMDNJ settled the allegations in September 2009 by paying $8.3 million (RMC 10/5/09, p. 4). Several of the cardiologists also entered into civil agreements with the feds, while two pleaded guilty to embezzlement charges (RMC 3/10/08, p. 6). The jury found after a March 22-24 trial that cardiologist Joseph Campbell had a bona fide relationship with UMDNJ as a part-time clinical professor, says his attorney, Richard Robins. Campbell refused to enter into a civil settlement with the feds because he believed he did nothing wrong. Robins adds. “It was our position that he did not participate in any kickback scheme. He believed he was entering into a legitimate employment contract and was paid a salary for services rendered,” Robins says. Besides his employment contract with UMDNJ, Campbell also had staff privileges at numerous hospitals, to which he referred many patients, which Robins says is further proof that he was not involved in a referral/kickback scheme. Contact Robins at rrobins@bracheichler.com.

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